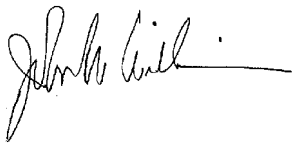
UNITED STATES DEPARTMENT OF AGRICULTURE
Farm Service Agency
Washington, DC 20250

Notice PM-2251

For: State and County Offices, Kansas City Offices, and APFO

Changes to the Office of Workers' Compensation Program (OWCP) Policies and Procedures

Approved by: Deputy Administrator, Management



1 Overview

A Background

On July 2, 1999, former President Clinton signed the Federal Worker 2000 Presidential Initiative establishing improved timeliness of injury reporting as a major goal for Federal agencies. Over the next 5 years, agencies are expected to improve timeliness on reporting injuries and illness by 5 percent each year. The Secretary of Labor will report to the President on the timeliness of CA-1, CA-2, CA-2a, and CA-7 submissions by agencies each year.

Federal agencies are required by regulation to submit an employee's Notice of Injury forms (CA-1, CA-2, and CA-2a) within 10 workdays (or 14 calendar days) of receipt from an employee, if lost time from work or medical expenses are claimed or anticipated according to 20 CFR 10.110 (a). Regulations require that CA-7 be submitted no later than 5 workdays (or 7 calendar days) upon receipt from the employee according to 20 CFR 10.112 (b).

B Purpose

This notice advises all State and County Offices of changes to OWCP's policies and procedures.

Continued on the next page

Disposal Date	Distribution
September 1, 2001	State Offices, Kansas City Offices, and APFO; State Offices relay to County Offices

1 Overview (Continued)

C
Contact

Direct questions about this notice as follows.

IF the employee's duty station is. . .	THEN contact...
State Office	Maria T. Ruiz, HRD, PMBAB at 202-418-9034 or e-mail at Maria_Ruiz@wdc.fsa.usda.gov
County Office	State Office
KCAO, APFO, KCCO, KCFO, KC-ITSDO, KC-ITSTO, or RMA-KC	Sue Collins or Mary Harvey, KCAO, Personnel Division at 816-926-6643

D
Additional Information

Additional information may be found at web site www.usda.gov/da
Click on "Safety and Health".

2 Assigning Proper Codes When Processing CA Forms

A
Coding the Shaded Area

During an analysis of OWCP data, it was determined that approximately 20 percent of CA-1, CA-2, and CA-2a received by OWCP are coded incorrectly. These coding inaccuracies can be serious program deficiencies. To ensure the coding is correct, State Offices shall:

- use the Injury/Illness, Source/Type codes found in Publication CA-810, Appendix B, which can be downloaded from the web site www.nfoweb.com
- limit the practice of classifying Injuries/Illness as "Unclassified" or "Unknown" unless absolutely necessary
- establish an internal review process to ensure that forms are not forwarded to the Department of Labor (DOL) unless properly coded.

In most cases, sufficient information is available from the narrative description of the injury/illness to make an accurate classification.

Continued on the next page

2 Assigning Proper Codes When Processing CA Forms (Continued)

B
Occupational Code

The occupational code is made up of the employee's pay plan and occupational series.

Example: If the employee's pay plan is "GS" and occupational series is "0203", then the occupational code for that individual employee will be "GS-0203". DOL requires that the "Occupational Code" block be completed when processing CA-1, CA-2, and CA-2a. See Exhibit 1. Since every employee does not have the same occupational code, the occupational code must be verified by either of the following:

- employee's last SF-50
- National Finance Center (NFC) Data Base, IRIS Screen 122, pay plan line.

C
Injury/Illness and Source/Types Codes

It is required that Injury/Illness and Source/Types Code blocks be completed when processing CA-1, CA-2, and CA-2a. See Exhibit 1.

Note: Refer to CA-810 Appendix B for Source/Type codes.

D
Agency Chargeback Codes

DOL has activated new Agency chargeback codes to identify State and County FSA employees. Alpha numerical extension letters have been added behind the 4-digit Agency chargeback codes representing each respective State abbreviation. OSHA **requires** that the "Agency Chargeback Code" block be completed when processing CA-1, CA-2, and CA-2a.

Example: An employee located in Illinois would be assigned an OWCP Chargeback of 8505-IL. See Exhibit 2.

Note: Refer to Notice PM-2239 for chargeback codes.

Continued on the next page

2 Assigning Proper Codes When Processing CA Forms (Continued)

E
OSHA Site Code

OSHA **requires** that the "OSHA Site Code" block be completed when processing CA-1, CA-2, and CA-2a.

The OSHA Site Code should be the organizational structural code assigned to the employee's position. The organizational structural code may be verified by using either of the following:

- employee's last SF-50
- NFC Data Base, IRIS Screen 122, organizational structural line.

The OSHA Site Code for:

- State Office employees begin with the letters FA
- County Office employees begin with the letters CE.

The code should then be carried out to the 12 digits including FA or CE. See Exhibit 2.

Example: CE-03-46-0087-00.

3 Maintaining SF-66 Medical Files

A
Establishing SF-66 Medical Files

When an injury is reported, an SF-66 medical file (blue folder), shall be established. The SF-66 medical file shall include the following pertaining to the case:

- copies of all CA forms
- medical documentation
- medical bills (if possible)
- doctor's certificate of absenteeism
- employee's T&A
- employee's FSA-958
- employee's SF-71
- calendar showing **COP** days, if applicable
- correspondence from DOL
- Agency correspondence, if applicable
- important notes
- other correspondence.

Continued on the next page

3 Maintaining SF-66 Medical Files (Continued)

A Establishing SF-66 Medical Files (Continued)

Note: SF-66 medical files shall be kept in a central location in the office under lock and key. The information in SF-66 files is protected by the Freedom of Information Act and it belongs to DOL.

Do not destroy or dispose of any of the information in the file except for duplicates.

B Forwarding SF-66 Medical Files Upon Separation or Retirement

IF the employee...	THEN...
retires, dies, or resigns	the SF-66 medical file shall be sent to the National Personnel Records Center together with the employee's Official Personnel Folder. **Note:** Maintain a log with the name, case number, day of injury, and Social Security number of all SF-66 medical files sent to the National Personnel Records Center for future reference.
transfers to another agency	• make a copy of the entire SF-66 medical file for your records • forward the original SF-66 medical file to the employee's new Personnel Office.

C Ordering SF-66 Folders and CA Forms

SF-66 folders and all OWCP forms can be ordered from the:

- Consolidated Forms and Publications Distribution Center
  Beltsville Service Center
  6351 Ammendale Road
  Beltsville, MD 20705

- web site address www.lsc.usda.gov.

Example of CA-1 for Federal Employees

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Doe, John E.
2. Social Security Number: 000-00-0000
3. Date of birth (Mo. Day Yr.): 02 03 71
4. Sex: [X] Male [ ] Female
5. Home telephone: (000) 737-4050
6. Grade as of date of injury: Level 12 Step 06
7. Employee's home mailing address (include city, state, and ZIP code): 348 Fairbank Rd. Oregon, Illinois 00917
8. Dependents: [X] Wife, Husband [X] Children under 18 years [ ] Other

Description of Injury

9. Place where injury occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine): OGLE County FSA Office 213 W Pines Rd. Oregon, IL 61061
10. Date injury occurred (Mo. Day Yr.): 03 19 01
Time: 1:00 [ ] a.m. [X] p.m.
11. Date of this notice (Mo. Day Yr.): 03 19 01
12. Employee's occupation: Personnel Management Specialist
13. Cause of injury (Describe what happened and why.): While on my way to the copy machine my right foot was caught on the carpet, twisting right ankle and causing me to fall.
a. Occupation code: GS-1101
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg.): As a result my right ankle was swollen with pain on right foot, ankle and leg.
b. Type code: 210
c. Source code: 0110
OWCP Use - NOI code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

[X] a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

[ ] b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf *John E. Doe* **Date** *3/19/01*

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury.)

Name of witness | Signature of witness | Date signed

Address | City | State | Zip Code

Form CA-1
Rev. Jan 1997

Continued on the next page

Example of CA-1 for Federal Employees (Continued)

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and ZIP code)
OGLE County Farm Service Agency
P.O. Box 216
OWCP Agency Code: 8505-IL
OSHA Site Code: FA-17-82-2001-01

18. Employee's duty station (Street address and zip code) ZIP Code
Oregon, IL 61061-0216

19. Employee's retirement coverage: ☐ CSRS ☒ FERS ☐ Other, (identify)

20. Regular work hours: From: 7:00 ☒ a.m. ☐ p.m. To: 3:30 ☐ a.m. ☒ p.m.

21. Regular work schedule: ☐ Sun. ☒ Mon. ☒ Tues. ☒ Wed. ☒ Thurs. ☒ Fri. ☐ Sat.

22. Date of injury	23. Date notice received	24. Date stopped work	
Mo. Day Yr.	Mo. Day Yr.	Mo. Day Yr.	
03 19 01	03 19 01	03 19 01	Time: 1:30 ☐ a.m. ☒ p.m.
25. Date pay stopped	**26. Date 45 day period began**	**27. Date returned to work**	
Mo. Day Yr.	Mo. Day Yr.	Mo. Day Yr.	
03 19 01	03 20 01	03 19 01	Time: 7:00 ☒ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☒ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☒ No

30. Was injury caused by third party? ☐ Yes ☒ No (If "No," go to item 31.)

31. Name and address of third party (include city, state, and ZIP code)

32. Name and address of physician first proving medical care (include city, state, and ZIP code)
Dr. Sue Horsefeather
"The Horsefeather Clinic"
0020 Rock Ave., Rockford, IL 61103

33. First date medical care received: Mo. Day Yr. 03 19 01

34. Do medical reports show employee is disabled for work? ☒ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☒ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.
N/A

37. Pay rate when employee stopped work
$ 49,580 Per Annual

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor *(Type or print)*

Signature of supervisor Date

Supervisor's Title Office phone

39. Filing instructions
- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☐ No lost time, medical expense incurred or expected: forward this form to OWCP
- ☒ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

Form CA-1
Rev. Jan. 1997

Example of CA-1 for Non-Federal Employees

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Doe, John E.
2. Social Security Number: 000-00-0000
3. Date of birth (Mo. Day Yr.): 02 03 71
4. Sex: [X] Male [ ] Female
5. Home telephone: (000) 737-4050
6. Grade as of date of injury: Level 12 Step 06
7. Employee's home mailing address (include city, state, and ZIP code): 348 Fairbank Rd. Oregon, Illinois 00917
8. Dependents: [X] Wife, Husband [X] Children under 18 years [ ] Other

Description of Injury

9. Place where injury occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine): Main floor, Hancock County FSA Office, 102 Buchanan, Carthage, IL 62321
10. Date injury occurred (Mo. Day Yr.): 03 19 01
Time: 1:00 [ ] a.m. [X] p.m.
11. Date of this notice (Mo. Day Yr.): 03 19 01
12. Employee's occupation: Personnel Management Specialist
13. Cause of injury (Describe what happened and why.): While on my way to the copy machine my right foot was caught on the carpet, twisting right ankle and causing me to fall.
a. Occupation code: C0-1101
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg.): As a result my right ankle was swollen with pain on right foot, ankle and leg.
b. Type code: 210
c. Source code: 0110
OWCP Use - NOI code:

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

[X] a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

[ ] b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf *John E. Doe* **Date** *3/19/01*

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury.)

Name of witness | Signature of witness | Date signed

Address | City | State | Zip Code

Form CA-1
Rev. Jan 1997

Continued on the next page

Example of CA-1 for Non-Federal Employees (Continued)

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and ZIP code)
Hancock County Farm Service Agency
102 Buchanan St., Carthage, IL 62321
OWCP Agency Code: 8505-IL
OSHA Site Code: CE-03-46-0087-00

18. Employee's duty station (Street address and zip code) ZIP Code
102 Buchanan St., Carthage, IL 62321

19. Employee's retirement coverage
☐ CSRS ☒ FERS ☐ Other, (identify)

20. Regular work hours
From: 7:00 ☒ a.m. ☐ p.m. To: 3:30 ☐ a.m. ☒ p.m.

21. Regular work schedule
☐ Sun. ☒ Mon. ☒ Tues. ☒ Wed. ☒ Thurs. ☒ Fri. ☐ Sat.

22. Date of injury	23. Date notice received	24. Date stopped work	
Mo. Day Yr.	Mo. Day Yr.	Mo. Day Yr.	
03 19 01	03 19 01	03 19 01	Time: 1:30 ☐ a.m. ☒ p.m.
25. Date pay stopped	**26. Date 45 day period began**	**27. Date returned to work**	
Mo. Day Yr.	Mo. Day Yr.	Mo. Day Yr.	
N/A	03 20 01	04 12 01	Time: 7:00 ☒ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☒ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☒ No

30. Was injury caused by third party? ☐ Yes ☒ No (If "No," go to item 31.)

31. Name and address of third party (include city, state, and ZIP code)

32. Name and address of physician first proving medical care (include city, state, and ZIP code)
Dr. Sue Horsefeather
"The Horsefeather Clinic"
0020 Rock Ave., Rockford, IL 61103

33. First date medical care received: Mo. Day Yr. 03 19 01

34. Do medical reports show employee is disabled for work? ☒ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☒ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.
N/A

37. Pay rate when employee stopped work
$ 49,580 Per Annual

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor *(Type or print)*

Signature of supervisor Date

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☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
☐ No lost time, medical expense incurred or expected: forward this form to OWCP
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☐ First Aid Injury

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